TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy and Discount, L.L.C.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-17-0028-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
September 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sentrix Pharmacy and Discount, LLC (the "Pharmacy") requests payment for the services rendered to [the injured worker] on 5/13/16."

Amount in Dispute: $3,494.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Further research of the dispute packet filed with the Division found that the date of service on the table of disputed services is 5/13/16; however the Office is not in receipt of billing for this date of service from this provider."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2016	Pharmacy Service – Compound	$3,494.84	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Submitted documentation does not include explanations of benefits for the date of service in question.

Issues

Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement for the disputed compound?

Findings

Sentrix is seeking reimbursement of $3,494.84 for a compound dispensed on May 13, 2016. State Office of Risk Management contends that "Further research of the dispute packet filed with the Division found that the date of service on the table of disputed services is 5/13/16; however the Office is not in receipt of billing for this date of service from this provider."

28 Texas Administrative Code §133.307(c)(2) requires that a request for medical fee dispute resolution include, in part "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter…"

Review of the submitted documentation does not find a paper copy of a medical bill for the date of service in question. Therefore, the division concludes that the documentation does not support that the compound in question was submitted to State Office of Risk Management. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.